FINNISH SOCIAL PROTECTION IN 2002

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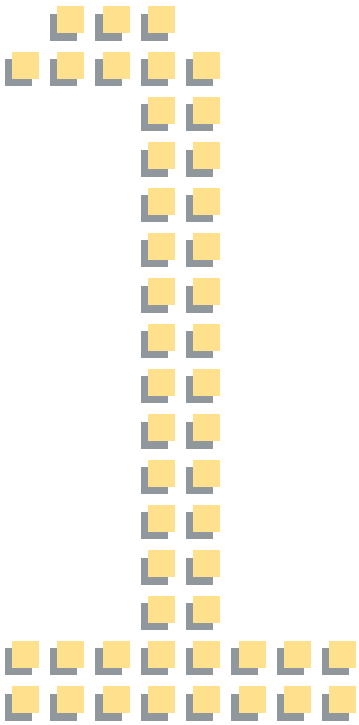
CONTENTS



1. THE FINNISH SOCIAL PROTECTION SYSTEM – A SUMMARY

Basic elements in Finnish social protection

The basic elements in the Finnish social protection system are preventive social and health policy, social and healthcare services, and social insurance. The main aim of social protection is to safeguard people's income by providing a comprehensive system of basic security and income-related benefits, which guarantee a reasonable level of consumption in different risk situations. An important element in the Finnish social protection system is the comprehensive social and health services it provides.

The social protection system has been built up over several decades and it is characterized by universality of benefits. As in other Nordic countries, it is primarily residence in the country that qualifies a person for social protection.

The social protection system has guaranteed social cohesion, fairness and equality. Almost all households get some kind of income transfer or use social and health services from time to time. During the severe economic recession in the early 1990s, the role of social protection was mainly to act as a safety net in coping with high unemployment. The system of income transfers has effectively levelled out income distribution, which is fairly even in Finland, measured in terms of households' disposable income. The poverty rate is one of the lowest in the EU.

The principle of equality is firmly incorporated into the social protection system. The vigorous development of the daycare system for small children has enabled women to participate widely in working life, and about 70% of mothers of young children do so. All children under school age (7 years) have the right to municipal daycare.

Social expenditure near EU average

The ratio of social expenditure to GDP rose considerably in Finland during the economic recession at the beginning of the 1990s. Economic growth, savings in public expenditure, a drop in unemployment and reform measures have subsequently lowered the level, however, and it is now near the EU average. In 2002, social protection expenditure accounted for 26.1% of GDP. Social expenditure is mainly financed by employers, central government and the municipalities. The direct contribution to social protection expenditure made by the insured is far lower in Finland than in other EU countries, and the financial contribution of central government and the municipalities is correspondingly higher. This is a typical feature in countries with benefits based on universality.

Close connection between preventive action and social and health services

Preventive action is an integral part of social protection in Finland. Its aim is to forestall a range of risks and problems so that use of the more expensive services and forms of assistance can be minimized. People are encouraged to look after their own health and to cut their use of tobacco and alcohol. The main areas of preventive action are environmental healthcare, effective primary healthcare, occupational healthcare, maternity and child welfare services, and the prevention of poverty and social exclusion.

The municipalities are responsible for arranging basic services like schooling, social services and health services. Most municipalities have less than 10,000 inhabitants. Statutory services are provided by municipal institutions, either the municipality's own or joint bodies run together with other municipalities. The municipalities can also buy these obligatory services from the private sector.

Both central government and the municipalities have the right to levy taxes. The municipalities re-

ceive a central government grant to enable them to arrange the services they are obliged to provide. Clients have to pay a fee for the services they use. The most important areas in the service sector are primary healthcare and specialized medical care, children's daycare, care of older people, services for people with disabilities, social assistance and child welfare. Social assistance is a last-resort benefit. Private services supplement the public services.

Certain benefits, such as parental leave and child allowance, are universal. The level of child allowance depends on the number of children in a household, and is payable for children under 17. Child allowance is non-taxable. All parents have the right to take parental leave, and fathers resident in Finland have the right to a separate paternity allowance for 6–18 working days. When a baby is born, the family also receives a maternity pack that contains clothes and baby care requisites. All children under school age (7 years) have the right to municipal daycare or, alternatively, their families can receive financial support for private daycare or home care for their children. The municipalities are obliged to arrange pre-school education for all children aged 6.

Comprehensive and statutory social insurance

In Finland, all residents are covered by social security schemes which govern basic pensions (national pensions), sickness and maternity benefits and unemployment benefits. In addition, all employed persons are entitled to benefits based on employment, such as employment pensions and benefits for employment-related accidents. A distinctive characteristic of the social insurance system in Finland is that a large proportion of social insurance is managed by private insurance institutions, although the system is obligatory and statutory.

Finland has two pension systems: the national pension scheme and the employment pension scheme. Both schemes pay old-age, disability and survivor's pensions. The national pension scheme provides pensions on the basis of residence to guarantee a minimum income, whereas the other scheme is based on employment and related to earnings. The national pension is coordinated with pension from the employment pension schemes and paid to persons with a low or no employment pension. When the employment pension exceeds a certain amount, there is no entitlement to national pension. National pensions are administered by the Social Insurance Institution (Kela). The employment pension schemes are managed by private insurance institutions. The Central Pension Security Institute (ETK) is the central body and the public sector has its own pension institutions.

Unemployment benefits consist of earnings-related allowance, basic allowance and labour market support. Most employees are covered by their own sector's unemployment fund, in which case they are entitled to an earnings-related allowance.

All employed persons and farmers are covered by mandatory insurance against employment injuries and occupational diseases. Self-employed persons other than farmers can take out voluntary insurance. The employment accident insurance scheme is administered by private insurance companies. Motor vehicle third-party liability insurance is obligatory in Finland.

National health insurance compensates for income lost due to temporary incapacity for work. The allowance is proportional to the applicant's earnings. A lengthy illness or period of disability can affect the everyday life of the person concerned in various ways. Rehabilitation can help prevent and alleviate these effects. Rehabilitation benefits are provided in order to improve and maintain the capacity of persons with handicaps or severe disabilities to work and cope with their everyday lives as well as possible, despite their condition.

According to opinion polls, the Finnish social protection system enjoys widespread public support.

Challenges to face

The main domestic challenges for social policy in the coming years are

- to achieve a balanced national economy
- unemployment, especially long-term unemployment
- demographic changes and changes in family structure
- raising the employment rate and maintaining work ability
- providing the care and services needed by an ageing population
- to assure availability of sufficient competent personnel in the social and healthcare sector
- managing the projected expenditure on social and healthcare services
- poverty and social exclusion
- sustainable financing of social expenditure
- the new information technology

Due to structural reforms in the pension system and curbs on public spending and the better employment situation, the financing of the system is now on a firmer footing than during the recession in the early 1990s. The financing of pension security for the baby-boom generation will require moderate growth in the economy and a lower unemployment rate than at present, however.

How to modernize social protection?

In April 2001, the Ministry of Social Affairs and Health published 'Strategies for Social Protection 2010 – towards a socially and economically sustainable society', a strategic document summing up the social protection strategy for the next ten years. This summed up the strategy for reform of the social protection system along four strategic lines:

- promoting health and functional capacity;
- making work more attractive;
- preventing and combating social exclusion;
- providing efficient services and income security.

These four lines of policy set out the objectives and describe the main measures needed for their implementation.

If these objectives can be implemented, people in 2010 will be staying on at work for 2–3 years longer than now, the general functional capacity of the population will have improved, older people will not need care until a more advanced age, and the health differences between population groups will have been reduced. The quality and availability of services will have been improved through increasingly efficient regional cooperation, income transfers will secure a reasonable income for people while still providing an incentive to work, social protection will have a secure funding base, and poverty will be held at the low level of the past few decades.

In 2002, the Committee on Social Protection Expenditure and its Financing published its proposals for reform of the Finnish social insurance system. They were based partly on the agreement between the social partners to improve the sustainable financing of earnings-related pensions. Implementation of the proposed reforms would extend people's working careers beyond their present length.

EU as an operational framework

Under the principle of subsidiarity, social policy comes within the competence of Member States. Nevertheless, the European Union is increasingly the environment in which social policy has to operate. The euro area now covers 12 countries, including Finland, and has generated further discussion about the financing of social protection. While the main impact of EMU is clearly positive, as interest rates have been falling and the economy expanding, the risk of asymmetric shocks is nevertheless still real within the framework of the Stability and Growth Pact.

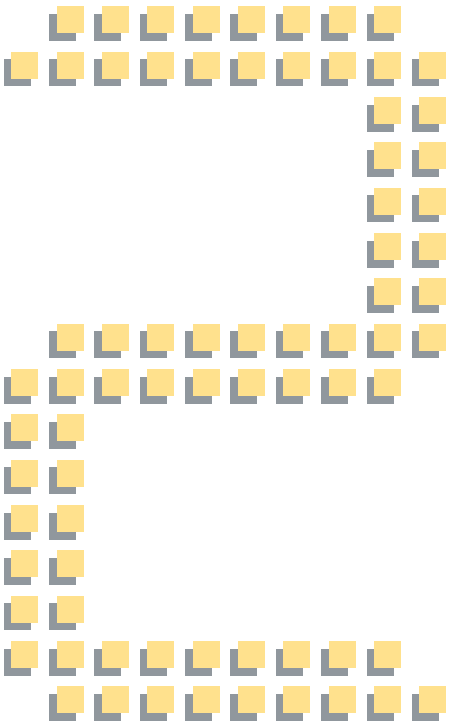
The entry into force of the Treaty of Amsterdam reinforced the social dimension at the EU level. The Treaty of Nice will further strengthen the position of social policy, as it includes confirmation of the legal basis of the new Social Protection Committee (art. 144). Common challenges shared by the entire Union include raising the employment rate, combating poverty and social exclusion, an ageing population and sustainable financing of the pension systems and healthcare. These challenges are closely connected with the process of EU enlargement.

The basic question is how to successfully combine macroeconomic policy, employment policy and social policy in order to improve the competitiveness of the European Union. Improving the social dimension of the EU means better coordination of national policies and strengthening the common framework for European social policy. The Open Method of Coordination (OMC) is a new form of cooperation at European level that integrates national diversity and European unity in a potentially fruitful way. It is a key element of the Lisbon Strategy accepted by the Lisbon European Council in 2000. Under the OMC, Member States can set common objectives and agree follow-up indicators, reporting and benchmarking. So far, such common objectives have been agreed in the areas of poverty and social exclusion, pension policy and healthcare. They provide useful guidelines for further work in these areas at national level.

Strategic goals of the social affairs and health sector for 2001 and 2002

- To strengthen the activating elements of social protection and to secure its financing
- To support employees to maintain their capacity to work and to continue in working life
- To reduce poverty and social exclusion
- To support healthy lifestyles, general fitness and a good living environment
- To guarantee the standard of social and healthcare services and increase the effectiveness of care models
- To promote gender equality
- To increase the efficiency of steering and monitoring within the sector

These aims were based on the strategic guidelines followed in previous years and the priorities of the Government Programme of Paavo Lipponen's second Government, which began its term of office in April 1999.



2. SOCIAL PROTECTION IN 2002

SOCIAL PROTECTION EXPENDITURE AND USE

In 2002, social protection expenditure totalled EUR 36.5 billion. Of this, 35.3% was financed through the Budget, with 22.4% falling under the main heading of the Ministry of Social Affairs and Health. Social protection is also financed through other expenditure headings in the Budget. As before, the bulk of this expenditure consisted of income transfers to households, municipalities and joint municipal boards. The percentage of off-budget financing was down on the previous year. (Figure 1)

Social protection expenditure has grown at a moderate rate over the past few years. In 2002, social protection expenditure against GDP stood at 26.1%. This was below the EU average. The only countries where the expenditure level adjusted according to purchasing power parity was lower than in Finland were Ireland and the three Member States in southern Europe. Until 2002, Finnish social expenditure grew at a slow and steady pace (Table 1, Figure 2).

The Finnish social protection system is cost-effective; although social protection expenditure is lower than in the EU on average, the system is able to provide a reasonable level of social welfare and health services and income security for the whole population.

The total number of recipients of daily unemployment allowance and labour market support has continued to fall, but as a consequence of the weakened economic climate, the number of recipients of earnings-related and basic daily unemployment allowance began to rise again towards the end of the year, as did the number of recipients of social assistance. The number of people on disability pensions has fallen. The number of people receiving old-age pensions is rising steadily every year as the population ages. The increase in the number of employed people has resulted in an increase in the number of people receiving daily sickness allowance. The need for parental allowance and child daycare allowances fell as a consequence of a fall in the birthrate. (Table 2)

FINANCING OF SOCIAL PROTECTION

Finnish social protection is financed through employer contributions and contributions by the insured, and through taxes and client charges. A rise in the employment rate has increased the share financed by employers and reduced that of central government. Financing from municipalities and the insured has remained more or less unchanged in recent years (Table 3).

There is no uniform European model for financing social protection. In countries with universal social protection systems, the financing contribution of the public sector is higher than average. In most EU countries, the contributions by the public sector and the insured have increased slightly, while employers' contributions have fallen.

Figure 1. Percentage of social protection expenditure financed through the Budget in relation to all social protection expenditure in 2002

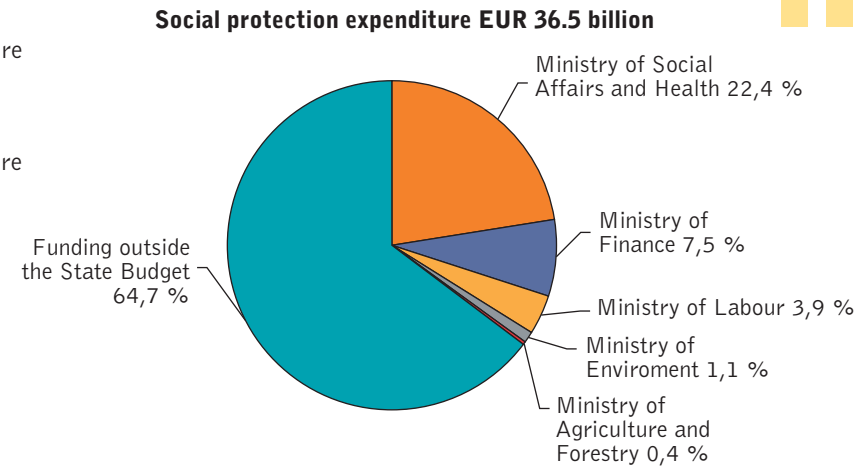


Figure 2. Social protection expenditure per capita in EU Member States in 2000 (in euros by purchasing power parity)

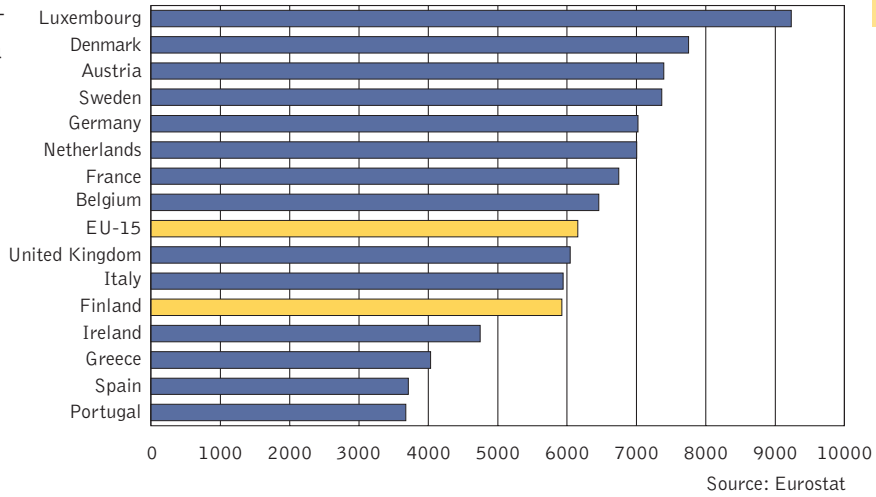


Table 1. Trends in social protection expenditure

	1995	2000	2001	2002*
Total social protection expenditure, billion EUR	30,2	33,1	34,8	36,5
Expenditure from the main title of the Ministry of Social Affairs and Health, billion EUR	8,2	7,3	7,6	8,2
Social protection expenditure/GDP,%	31,7	25,4	25,6	26,1

* estimate

Table 2. Recipients of social protection benefits 1995–2000 (1,000 people)

Benefit	1995	2000	2001	2002*
Pension recipients, total, Dec. 31**	1157	1224	1233	1240
Daily unemployment allowance	827	603	580	568
Daily sickness allowance	284	296	301	321
Parental allowance (mothers), Dec. 31	53	49	47	46
Child daycare allowances, Dec. 31 (children)	138	126	124	122
Social assistance	584	454	443	446

* estimate ** excluding recipients of survivor's pension only

SOCIAL AND HEALTHCARE POLICY

Social protection expenditure is mainly made up of pensions, municipal social welfare and healthcare services, unemployment security and health insurance. The percentage of expenditure devoted to earnings-related pensions rose somewhat, while unemployment security fell. The changes in the percentages of these different expenditure items compared with the previous year are slight. (Figure 3)

Household income and income distribution

The growth in income differentials between households which had continued since the mid-1990s levelled out in 2001. The increase in income differentials has been largely due to a rise in capital income. In 2001, the capital income received by households fell noticeably, and this resulted in an overall reduction in income differentials. The equalizing effect of income transfers and taxation increased somewhat in 2001, something which also helped reduce income differentials. In 2001, income differentials were still clearly greater than they were in the early 1990s.

The relative poverty rates, the indicator for the percentage of low-income population, has begun to rise in recent years. This increase in relative poverty was largely due to a rise in the general income level, which has raised the relative poverty line which is tied to the population's average (median) income. Measured by a fixed poverty line adjusted for price changes alone, the percentage of low-income population has actually fallen in recent years. Most of the people currently below the poverty line are members of households where no member of the household has a job.

Relative poverty has grown in most family types. The biggest growth centres on single-parent families and families with children under school age. Low incomes are most widespread among young people living alone. The relative poverty rate of this group is increased by the high percentage of students it includes.

Compared with other EU countries, Finland has a very low poverty rate both among the population at large and among children, in particular. The poverty rate among older people in Finland is at about the level of the EU average. (Figure 4). Even a fairly low income may secure a reasonable standard of living if the household in question lives in housing it already owns and the housing loan has been paid. In Finland, it is more common for older people to own the flat or house where they live than in other EU Member States.

CASH BENEFITS

Income security benefits are income transfers paid in the form of cash benefits. These cash benefits accounted for about two-thirds of social protection expenditure. It is the function of statutory social protection to insure all citizens against the loss of income or the expenses incurred from illness, disability, unemployment, accidents, old age, widowhood, or the birth of a child.

The aim has been to finance basic benefits out of tax revenue, while employment-related benefits are financed with contributions from employers and the insured. Some forms of social assistance such as maintenance allowance and support and social assistance are funded out of tax revenue.

Table 3. Total financing of social protection in Finland from 1995 to 2002, financing contributions as percentages

Financing body	Contribution to financing of social protection, %			
	1995	2000	2001	2002*
Central government	29,1	24,0	23,3	23,1
Municipalities	16,7	19,2	19,4	19,3
Employers	37,7	37,7	38,8	39,2
Insured	13,7	12,1	11,6	11,7
Other income	6,9	7,1	6,9	6,6
Total	100,1	100,1	100,0	99,9

* estimate

Figure 3. Social protection expenditure by category in 2002, percentages of total expenditure, EUR 36.5 billion

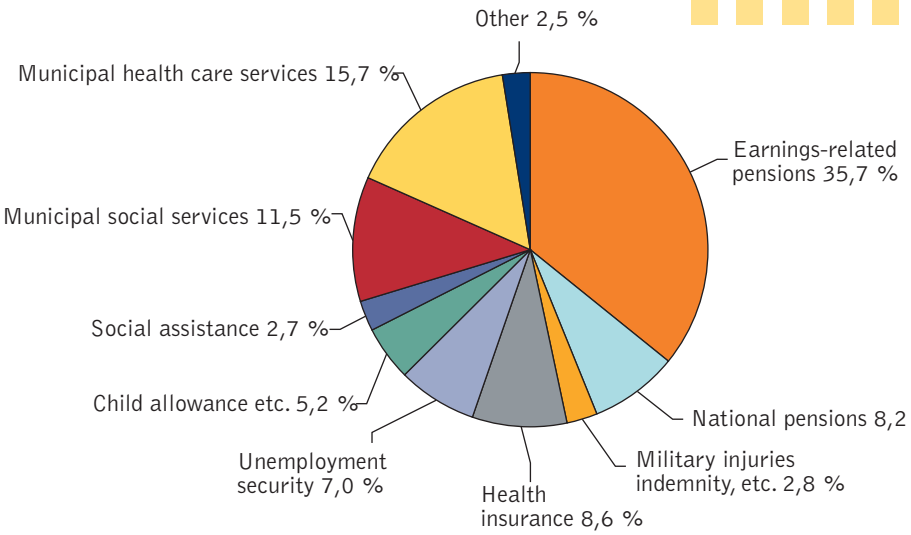
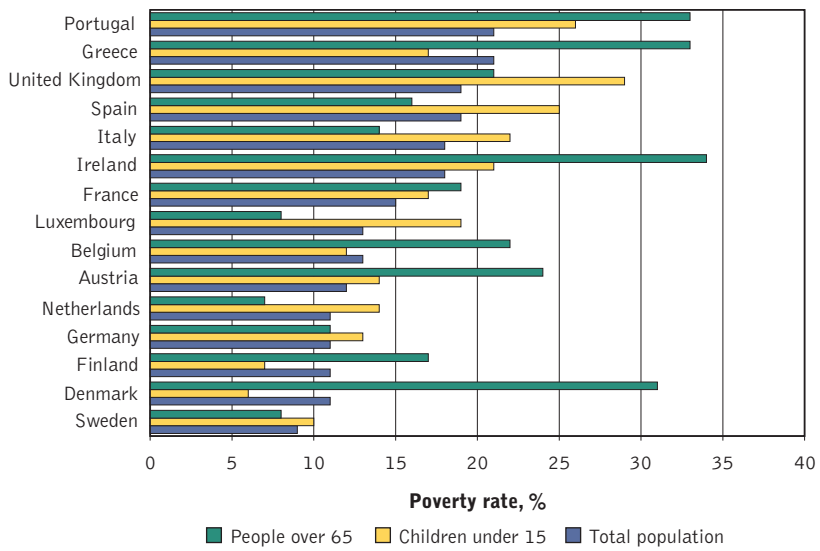


Figure 4. Poverty rates of total population, children under 15 and older people over 65 in the EU Member States in 1998



Poverty rate: 60 % of disposable income. New OECD consumer units
Source: Eurostat (ECHP)

Unemployment security

The purpose of unemployment security is to secure a reasonable income for unemployed people. Unemployment security is paid in the form of earnings-related daily allowance or basic daily allowance. Labour market support is paid to those who do not fulfil the conditions for receiving the daily allowances or who have already received the allowances for the maximum period. The unemployment security schemes are designed to take account of insurance principles and to retain incentives to return to work.

The uncertainty of the economic climate was reflected in the unemployment figures. In 2002, the growth of the employment rate and the fall in unemployment figures both slowed. The numbers of recipients of both earnings-related and basic daily unemployment allowance grew, but the duration of periods of unemployment fell. The number of recipients of labour market support fell. Long-term unemployment remained high, however.

The level of the daily unemployment allowance was raised in March 2002. The basic daily allowance was raised to EUR 22.72 per day. The average earnings-related daily allowance was EUR 41.3 a day in 2002.

The legislation on unemployment security was completely renewed during the year under review. Provisions on income security during unemployment were brought together in one new Act. At the same time, the following changes were made to unemployment security:

- Unemployment pensions will no longer be granted to those born after 1949. Instead, older workers with a long working career behind them will be eligible to receive unemployment security until they are 65 instead of the current 60.
- It was made easier to become eligible for daily unemployment allowance. The requirement for the period of work preceding unemployment was reduced from ten to eight months for those whose period of maximum daily unemployment allowance was about to start again from the beginning.
- The system of 'redundancy payments' was stopped. For those with a long working career, redundancy pay will be replaced with an increase in the amount of earnings-related daily allowance paid.

Central government funds labour market support and basic daily unemployment allowance. Income from employee unemployment insurance contributions for employees who are not members of unemployment funds is also channelled into the funding of the basic daily allowance.

The earnings-related benefits paid by the unemployment funds are financed by unemployment funds, employer and employee contributions and central government. The unemployment funds pay 5.5% of earnings-related unemployment benefit while central government finances a part equivalent to basic daily unemployment allowance. The rest is financed by the Unemployment Insurance Fund from employer and employee contributions. The Fund has set up an unemployment security buffer fund to ensure liquidity and even out fluctuations in unemployment insurance contributions. In the year under review, the assets of the buffer fund exceeded the maximum decreed, and as a consequence, unemployment insurance contributions were reduced.

National health insurance

The aim of health insurance compensation is to complement public healthcare by providing access to reasonably priced healthcare services from the private sector and medicines prescribed for out-patient care.

Daily sickness allowance and rehabilitation allowance for low-income brackets were raised in 2002 in compliance with the measures to combat poverty which were decided in spring 2001. Income security during periods of illness was improved for unemployed people who find work, students, rehabilitation patients, and people with low or no income, by expanding the coverage of the benefit. Students' daily sickness allowance was raised to the same level as the financial aid to students.

The number of dentists' appointments reimbursed by sickness insurance has grown significantly since the entitlement to such reimbursement was expanded in 2001 to everyone born in 1946 and later. In December 2002, the right to reimbursement for dental care was expanded to cover the entire population.

Reimbursement for medicines grew by about 10% in 2002 due to increased use of medicines and to the inclusion of new and more expensive medicines in the reimbursement scheme. In order to make the use of medicines more cost-effective and ensure appropriate use, Finnish pharmacies have been obliged as of spring 2003 to substitute the cheapest corresponding medicine of the same pharmaceutical substance (generic substitution) for a prescribed drug.

Health insurance is funded from employer and employee contributions. Central government is responsible for funding the basic daily allowance. Health insurance contributions paid by employers remained at the same level as earlier. However, the contributions by employers and the insured did not cover the sum required for financing the health insurance system. The guarantee payment by central government rose to some EUR 625 million, or to one-fifth of all health insurance expenses. In addition, EUR 200 million of the revenues from value-added tax was paid into the sickness insurance fund.

Pension insurance

Recipients of pension on December 31.	1995	2000	2001	2002*
Old-age pension	804 100	869 700	875 600	892 300
– early old-age pension	42 400	64 700	57 800	57 000
Part-time pension	5 450	24 500	29 100	39 300
Disability pension	309 500	276 300	267 900	267 700
– individual early retirement pension	63 350	34 800	24 500	20 800
Unemployment pension	39 150	54 300	58 000	58 000
Survivor's pension	260 100	281 300	283 400	290 400

* estimate

Pension security is made up of earnings-related pension and national pension. The earnings-related pension is earned through a person's own work and is the primary form of pension security. The function of the national pension is to ensure that every resident of Finland receives a minimum pension. The popularity of part-time pensions continued to grow rapidly. Recipient numbers of other forms of early retirement pensions fell.

An extensive reform of private-sector pensions was approved in autumn 2002. The main aims of this new solution are to ensure the solvency of the earnings-related pensions system as life expectancy grows, to encourage people to stay on at work for 2-3 years longer than at present, to secure the labour supply, to simplify the pensions system, and to make the grounds for receiving pensions fairer. The main part of the reform will enter into force as of the beginning of 2005.

In the reform, the options for early retirement will be restricted in that those born after 1943 will no longer be entitled to individual early retirement pen-

sions, the age limit for part-time pension will be raised and conditions for entitlement will be made stricter. The age limit for old-age pension will become flexible, however, in future, people may choose to retire between the ages of 62 and 68. The pension agreement also comprised reform of the unemployment security system and improvement of occupational pension-related rehabilitation and pension is now accrued for periods of child care leave and study. The new pension system also prepares for growing life expectancy by introducing a 'lifespan coefficient' which will be applied to adjust new pensions for the first time in 2010.

Employment pensions are funded chiefly from employer and employee pension contributions. The average employment pension contribution remained at the previous year's level in 2002, 21.1% of wages. The contribution is divided so that the employer pension contribution is an average of 16.7% while that of employees is 4.4%.

National pensions are funded from employers' national pension insurance contributions, central government contributions and revenue from value-added tax. Central government contributions to national pension expenditure came to 29% and the government also funds child care allowances, disability allowances and pensioners' housing allowances in full. In 2002, the total sum came to EUR 1,145 million. In addition, EUR 500 million in revenue from value-added tax was paid into the national pension fund. Employers' national pension contributions fell during the year under review. As of March 2002, the employers' national pension contribution for private employers and state-owned companies was 1.35/3.55/4.45% of wages depending on the ratio between payroll and depreciations.

SOCIAL AND HEALTHCARE SERVICES

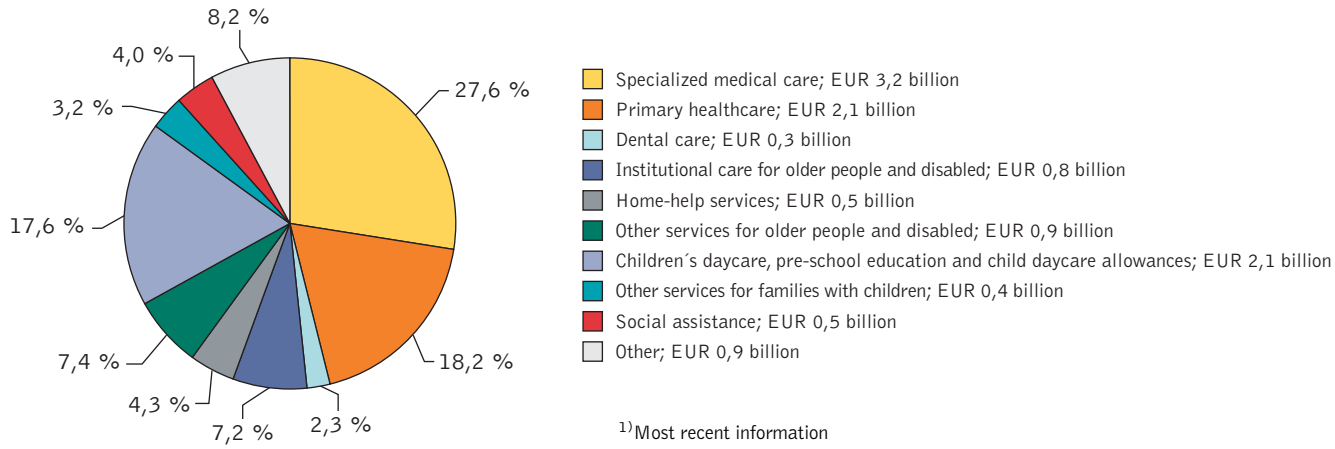
The strategic focus of social welfare and healthcare services was on improving the effectiveness of services and care procedures and the management and monitoring of services.

Nearly half of all social welfare and healthcare expenses are incurred by the municipalities from healthcare, and almost one-fifth from children's day-care and child care allowances (Figure 5). Advance estimates suggest that expenditure for healthcare and dental care grew in 2002. Meanwhile, expenditure on child care accounted for a lower percentage of municipal healthcare and social welfare expenditure than previously.

In 2002, municipal social welfare and healthcare expenditure came to an estimated EUR 12.1 billion. Out of this, EUR 2.7 billion was funded from the State Budget, EUR 2.5 of it being paid to municipalities in the form of government transfers towards operating costs. The government transfer received by a municipality is calculated from statistical factors such as the number of inhabitants and the individual municipality's particular factors of need and condition. In 2002, the government contribution to operating costs for social welfare and healthcare was raised from 24.2% to 25.4%.

Most of the expenditure for social welfare and healthcare services went on personnel costs. Municipal social welfare and healthcare staff numbered 243,800 in 2002, an increase of 2,400 on the previous year. Recruitment problems occurred in some areas and in the case of some professions, notably specialist physicians.

Figure 5. Municipal social welfare and healthcare expenditure in 2001[1)]



[1)] Most recent information

Centres of expertise in the social welfare sector

As of the beginning of the year under review, a permanent structure and funding framework were created for centres of expertise in the social welfare sector. There are eight regional centres of expertise and one national one for Swedish-speaking Finns. The network of centres of expertise covers the entire country and its sphere includes municipalities, universities, tertiary education and NGOs. A centre of expertise is a structure for regional cooperation with the purpose of pursuing high-quality development work in the sector and strengthening specialist skills, and ensuring that skills and expertise are passed on to all personnel in the sector. The operations take in the entire social welfare sector: social work, early childhood education and care, care for older people, child welfare, services for substance abusers and people with disabilities.

Social work

The Finnish Government has appointed a national Advisory Committee for social welfare for the period 2002–2005. The task of the Advisory Committee is to draw up an action plan for reinforcing the status of social welfare operations and strengthening cooperation between administrative sectors, NGOs and other parties in promoting social security and welfare. The main focus of development in social work continues to lie in regional cooperation and ensuring specialist skills. Work continues to clarify the division of labour and the professional hierarchies within the social welfare sector, particularly between social workers in municipal social welfare and graduates of social welfare training programmes at polytechnics.

Social assistance

Preliminary estimates suggest that a total of 450,000 people received social assistance in 2002; this is the equivalent of 8.5% of the population, and a slight increase on the previous year. The provisions concerning social assistance were temporarily amended as of April 1, 2002. The amendments marked the beginning of a three-year test period to investigate incentives to work. Under this experimental system, a minimum of 20% of the earned income of recipients of social assistance up to a maximum sum of EUR 100 a month will be disregarded when calculating the person's entitlement to benefits. The experiment is scheduled for 2002–2005.

Services for older people

As the health and work ability of the Finnish population has improved and more effective medicines have been introduced, older people are finding it much easier to manage in non-institutional community care; other important factors are rehabilitation, advanced assistive devices and the range of services available to support everyday life at home.

Implementation of the 'National Framework' for care and services for older people began in 2002. The recommendation has been well received in the municipalities and has proved an efficient instrument in practice. 306 municipalities already have an up-to-date strategy on care for older people.

The position of people who care for elderly family members in the home was improved through an amendment to the Social Welfare Act which entered into force as of the beginning of 2002. Family carers' statutory entitlement to leave was raised from one day to two days a month, and entitlement to statutory leave was expanded.

Two rapporteurs studied ways of making use of service vouchers more effectively in municipal home services. They proposed a model which would allow service vouchers to be introduced on a broad front in home services. The Ministry of Social Affairs and Health has initiated drafting of the relevant legislation based on this proposal.

Services for people with disabilities

The demand for services under the Services and Assistance for people with disabilities Act continued to grow and expenditure grew by about 15% on the previous year. 80% of the recipients of services and support measures were transport service recipients, half of whom were elderly. It is in fact largely the increased need for transport services among older people that has influenced the growth in expenditure.

The reform of the service structure in care for the mentally handicapped continued. Housing services and work and day centres were all increased further. Preparation continued on the quality recommendations for housing services for people with disabilities and assistive technology services.

Legislative amendments promoting employment for people with disabilities entered into force in early April, improving the employment opportunities of people with disabilities and particularly encouraging them to seek work on the open labour market. Young people's access to vocational rehabilitation was improved while also improving the incentive to transfer from disability pensions to working life, and making it easier to combine pensions and work.

Healthcare services

	1995	2000	2001*	2002*
Primary healthcare				
– outpatient visits/1,000 inhabitants	4 651	4 855	4 820	4 800
– dentists' visits/1,000 inhabitants	821	936	946	960
– discharges/1,000 inhabitants	44	54	52	53
– bed days/1,000 inhabitants	1402	1 495	1 442	1 490
Specialized medical care				
– outpatient visits/1,000 inhabitants	1 146	1 197	1 230	1 270
– discharges/1,000 inhabitants	194	181	175	185
– bed days/1,000 inhabitants	1 547	1 227	1 194	1 250

* estimate

Total healthcare expenditure came to almost EUR 1,900 per person, a total of EUR 10.1 billion in 2002. This was 7.2% of GDP (Figure 6), which is well below the average for both the OECD and EU Member States.

There was still a shortage of doctors at both health centres and hospitals, but the situation was no worse than in the previous year. More places in medical education were added in 2002.

In the year under review, there were 277 health centres, 71 of which were run by joint municipal boards while the rest belonged to individual municipalities. Outpatient care and wards at health centres continued at the previous year's level. There were about 4.8 appointments with doctors per inhabitant. In 2002, the use of outsourced services and temporary agency employees increased. They replaced about 380 vacancies that could not be filled, especially in emergency on-call duties.

Work continued on the quality recommendations for school healthcare.

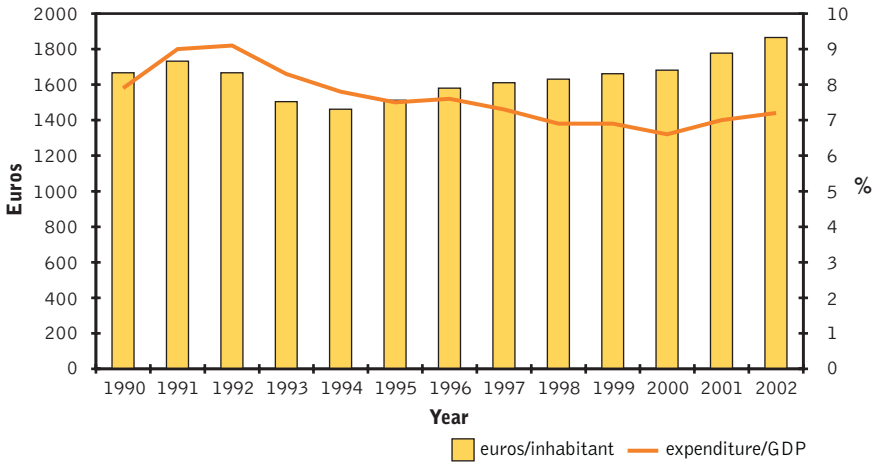
The effects of the prolonged doctors' strike in 2001 continued to be felt in hospitals in 2002. The number of referrals went up by more than 5%. This was a much bigger increase than in previous years. Most of the referrals came from health centres. About one in four referrals were patients of private doctors.

More patients than the year before were treated in hospital outpatient clinics, hospital wards and operating theatres. There were about 20,000 operations more than in 2001, but this could not fully make up for the backlog which had built up during the doctors' strike in 2001. In the supplementary State budget for 2002, the hospital districts were granted EUR 25 million in state subsidies to process queues for medical examination and care.

The State budget for 2002 comprised a supplementary appropriation for the third year running for the improvement of psychiatric services for children and young people. In 2002, work also started on putting the quality standards for mental healthcare services into practice in the field.

As of April 1, 2001, dental care refunds were extended to people born in 1946 or later. As of December 1, 2002, the dental care refunds have covered everyone, regardless of age. At the same time, the Primary Healthcare Act was amended to the effect that it was the task of the municipalities in 2002 to provide dental care for those born in 1946 or later, and for everyone regardless of age as of December 1, 2002. Most municipalities implemented this expansion over a transitional period.

Figure 6. Total healthcare expenditure at fixed prices, per inhabitant and against GDP 1990–2002



Medication

Municipal healthcare is responsible for the cost of medication administered during treatment. Patients are eligible for refunds for the cost of medication during outpatient care in accordance with the provisions of the Health Insurance Act.

Pharmaceutical expenditure continued to rise rapidly in 2002. This was largely due to the use of new and more expensive types of medication and, in part, to irrational prescription practices. A permanent development centre for pharmaceutical care was planned to replace the ROHTO project which promoted rational pharmaceuticals use, with the new centre to start operations in spring 2003. During the year under review, Parliament approved the new legislation concerning generic substitution, to enter into force in April 2003.

Rehabilitation

A Government report on rehabilitation was submitted to Parliament in 2002. The report focused especially on evaluation of the effectiveness of rehabilitation. Development measures for rehabilitation in the early 2000s focus above all on children and young people in danger of social exclusion, on helping employed people and ageing employees in particular to stay on at work, on improving the employment potential of the long-term unemployed and people with disabilities, and helping older people maintain their functional capacity.

Legislation promoting the employment of people with disabilities entered into force at the beginning of April 2002. It comprised amendment of the provisions on social welfare sheltered work and certain other amendments which improve the employment opportunities of people with disabilities.

FAMILY POLICY

In 2002, family policy was given a more prominent position on the Ministry's agenda than hitherto. Work began on developing a family policy strategy. During the year under review, the situation of families with children and the problems of children and young people received rather a lot of media coverage.

	1995	2000	2001	2002*
Children in municipal daycare Dec. 31	189 900	200 400	197 200	194 000
Children cared for with child daycare allowances Dec. 31	137 500	125 700	123 600	122 700
Children and young people in non-institutional care in child welfare during the year 1)	30 700	49 350	49 600	50 000
Recipients of child allowance Dec. 31	1 097 450	1 063 700	1 054 200	1 046 900
Recipients of parental allowance Dec. 31				
– mothers	53 340	48 570	47 450	47 000
– fathers	1 930	2 220	2 400	2 500

1) Espoo included in the statistics as of 2000

* estimate

No changes were made to the level of child allowances in 1995–2002. In the year under review, there were 7,300 fewer children receiving child allowance than in the previous year. There were no changes to the parental allowances either during the year under review. Paternity allowance became slightly more popular. At present, some 60% of fathers take advantage of their right to paternity leave. During the year under review, the Act respecting the Maternity Grant was amended so that maternity grants are also payable for international adoptions.

The Government approved a national policy definition on early childhood education and care and preparation began for an early education curriculum. As the number of children under school age fell, the number of children in municipal daycare fell to 194,000. Meanwhile, the number of children cared for using the private child care allowance went up to 14,700 (3% of all children under school age). During the year under review, 93% of 6-year-olds took part in pre-school education, which is free of charge.

In spring 2002, the Government submitted a report on the wellbeing of children and young people to Parliament. According to this report, the majority of children and young people in Finland are doing well, but it is important to intervene in the situation of children who are not doing well, in order to prevent exclusion. To this end, it was decided to allocate a separate state subsidy of EUR 15 million to the municipalities in 2003.

Tripartite cooperation between the social partners continued in order to improve the reconciliation of work and family life. An extensive information campaign was initiated in order to encourage people to use parental leaves.

In 2002, Finnish home care support began to be paid to families of employees stationed outside Finland or otherwise covered by the Finnish social protection system whose children have moved with their guardian to another EU or EEA Member State. Entitlement to home care allowance was also extended to families where one parent comes to work in Finland, regardless of whether the children are resident in another EU or EEA Member State.

PREVENTIVE SOCIAL AND HEALTHCARE POLICY

Preventive work focused on reinforcing the position and structures of preventive social and healthcare policy, promoting the health and welfare of children and young people, maintaining and improving the health, fitness and quality of life of the population as a whole, preventing social exclusion, developing preventive policy on substance abuse, and promoting a healthy and safe environment in general.

Abortions for young women have been on the increase since 1995. The general state of health of the population has improved, but health-related differences between different demographic groups are still considerable. Two thirds of the adult population considered their own health to be good or at least fairly good. Less than one in five people have a disease or injury that impairs their work ability or functional capacity.

Implementation of the Health 2015 public health programme continued during the year by developing health-promoting activities in different administrative sectors and by continuing to promote health on a local level.

The Government approved a resolution on the main guidelines for promoting health-enhancing physical activity. The guidelines emphasize the importance of cooperation across administrative boundaries and coordination of the work of public authorities and NGOs. In consequence, a Committee on Development of Health-Enhancing Physical Activity was appointed for 2002–2005.

A group of experts from the World Health Organization's Regional Office for Europe evaluated Finland's health-promotion activities. According to the evaluation, Finland's health policy guidelines and planning are well implemented. The evaluation emphasized the importance of reinforcing cooperation across administrative boundaries, securing adequate resources and aspects such as health impact assessment of planned projects.

The Act on Rehabilitative Work, which entered into force on September 1, 2001, required municipalities and employment offices to work together to draw up an activation plan and service package for each long-term unemployed client. It was estimated that there were about 106,500 such long-term unemployed at the end of 2002. Preliminary estimates indicate that activation measures have indeed helped unemployed people find work and gain entry into labour policy measures. This has also reduced their dependency on social protection. However, implementation of the Act has been hampered in many municipalities by a lack of funds reserved for the purpose.

A state subsidy in 2002 was used to start an experiment in the biggest cities, on combining services from the social services, the Social Insurance Institution (Kela) and the labour administration for those on labour market support. The aim was to help people on labour market support find work and to activate them in general, and also to maintain their work ability and rehabilitate them.

Social lending has made it possible to prevent low-income groups from economic exclusion and from falling into a vicious circle of escalating debts. This three-year experiment ended at the end of 2001. In 2002, work began to establish social lending as a permanent practice throughout the country.

Homelessness was alleviated slightly in the year under review. The number of individual homeless people fell by 400, but the number of families without homes remained unchanged. The targets for reducing homelessness in the present Government Programme have been implemented by increasing the sheltered housing offered by the social services to homeless people in need of particular support and care.

Consumption of alcoholic beverages was on the rise in Finland, with higher alcohol consumption in 2002 than ever before. By contrast, experimentation with illegal drugs appeared to have levelled out for the present. Alcohol-related illnesses and deaths continued to rise. The demand for social welfare and healthcare services due to alcohol and drug abuse also continued to rise.

During the year, quality recommendations for the development of municipal services for substance abusers were published. Several joint projects to improve the handling of drug problems and to prevent drug abuse also continued.

The Occupational Health Care Act entered into force on January 1, 2002. The Act emphasizes that operations should be arranged on the basis of individual workplace needs and the importance of maintaining employees' working capacity. The provisions on supervision have been clarified.

WORKING CONDITIONS AND OCCUPATIONAL SAFETY AND HEALTH

Preliminary figures for 2002 indicate that compensation was paid for about 130,000 occupational accidents and diseases, which was more than the previous year. The average period of sick leave has continued to become shorter over the past few years and the number of serious accidents leading to sick leave of more than one month is falling.

The number of accidents at work is high in the building industry especially. Meanwhile, the number of accidents in industry has fallen somewhat. The number of fatal accidents in the workplace and occupational diseases fell somewhat in 2002. Chemical agents and physical factors were the main causes of occupational diseases.

The number of sick leave days per employee began to rise. Sick leave was most common in industries which expose people to risk of musculo-skeletal disorders: industry, construction, agriculture and the social welfare and healthcare sector. The number of disability pensions continued to rise. The main reasons for such pensions were musculo-skeletal disorders and mental problems. The average retirement age has gone up slightly.

During the year under review, there were many positive developments in working life. Feelings of stress are still widespread among employees, however, and on the whole, people felt that job satisfaction was declining.

A new national programme to make work more attractive and promote the work ability and functional capacity of the working age population, the Veto programme, was prepared in cooperation with the other ministries and the labour market organizations. The aim of the programme is to improve wellbeing at work, coping with work, work ability, health and safety. Measures under the programme will be implemented in 2003–2006.

PROMOTING EQUALITY BETWEEN WOMEN AND MEN

A committee preparing the reform of the Act on Equality Between Women and Men submitted its report in November 2002. The committee's proposals included the introduction of gender impact assessment of legislative proposals, bringing educational institutions and trade unions within the sphere of application of discrimination as a concept, and creating legislative provisions which define sexual harassment as a prohibited form of discrimination.

In spring 2002, work started to mainstream gender equality in the operations of the Ministry of Social Affairs and Health. Implementation started with gender impact assessment of legislative projects, and the gender impact of eight projects was assessed.

During the year under review, the ministry was in charge of preparatory work for the sectoral councils for employment and social affairs and health, and prepared guidelines on EU issues in its administrative sphere. The Seville Council passed a decision to merge the sectoral councils for employment, social affairs, health and consumer affairs. This is an important decision, as issues touching the Ministry of Social Affairs and Health's administrative sphere are dealt with in a number of different Council structures in addition to the sectoral council.

A national report on pension strategy and a national report on healthcare for older people were prepared for the Commission using the open method of coordination. Based on the national reports on pensions strategy, the Commission and the Council drew up a report on pensions for the European Council. Work continued on several directives and on amendment of the decree for the coordination of social protection systems.

In the UN, the year's topics were the HIV/AIDS strategy, the Second World Assembly on Ageing, the Special Session on Children, and also sustainable development and the rights of people with disabilities. Work also continued together with the World Health Organization (WHO) to achieve an international Framework Convention on Tobacco Control. The Ministry also participated in an OECD health project.

The Ministry of Social Affairs and Health has participated in preparing Finland's position for sectoral negotiations on the liberalization of trade in services in the WTO Doha round now in progress.

A mid-term Action Plan for Cooperation with Areas in North-West Russia and the Baltic States in the Field of Social Protection and Health (2003–2005) was drawn up. Nordic cooperation focused on the rights of citizens of the Nordic countries.

OTHER ACTIVITIES IN THE SOCIAL AFFAIRS AND HEALTH SECTOR

The institutions and agencies under the Ministry of Social Affairs and Health can be divided into research and development institutions and permit and supervision authorities dealing with administrative matters. At the end of 2002, about 3,550 people worked in these units, including the Ministry itself. Ministry personnel totalled 465. Performance targets were set for each administrative unit in the sector, and these were laid out in a performance agreement signed by the Ministry and the units.

Slot Machine Association

The administrative sector of the Ministry of Social Affairs and Health includes the Slot Machine Association. This is the only body in Finland licensed to engage in slot machine and gaming operations. The Association's profits are distributed through the Budget to promote health and social welfare.

In 2002, the turnover of the Slot Machine Association went up to EUR 562 million, an increase of 1.6% on the previous year. Profit for the financial year came to EUR 385 million. In 2002, grants amounting to a total of EUR 297.5 million were distributed out of the profits of the Slot Machine Association to 1,117 NGOs promoting health and social welfare. In addition, EUR 97.75 million was allocated to the Finnish State Treasury for the rehabilitation of disabled war invalids and other war veterans.